**NC MEDICAID COMMUNITY BEHAVIORAL HEALTH TAXONOMY 251S00000X**

**PROVIDER ATTESTATION FORM**

**Provider name:** _____

**NPI:** _____

**Reference ID Number:** _____

When enrolling, re-enrolling, or completing re-credentialing/re-verification for taxonomy 251S00000X Community Behavioral Health, the Division of Health Benefits (DHB) must identify services being provided using this taxonomy. By completing this form, you are attesting that:

- Your services correspond with a procedure code within this taxonomy
- You are fully able to provide these services in the NC Medicaid program
- You are or will be contracting with at least one NC Behavioral Health Intellectual/Developmental Disabilities Tailored Plan

Please select the service(s) under Community Intervention Services (CIS) you are able to provide or if you are not a CIS provider, please mark last box below:

| | Services |
|---|---|
| | Ambulatory Detoxification |
| | Assertive Community Treatment Team (ACTT) |
| | Child and Adolescent Day Treatment (CADT) |
| | CIS Service Only |
| | Community Support Team |
| | Diagnostic Assessment |
| | Early Intervention Services |
| | Innovations Waiver Program |
| | Intensive in Home |
| | Medically Supervised or ADATC Detoxification/Crisis Stabilization |
| | Mobile Crisis Management |
| | Multisystemic Therapy (MST) |
| | Non-Hospital Detoxification |
| | Opioid Treatment |
| | Partial Hospitalization |
| | Peer Support Services |
| | Professional Treatment Services in Facility Based Crisis Program - Adult |
| | Professional Treatment Services in Facility Based Crisis Program - Child |
| | Psychosocial Rehabilitation |
| | Research Based – Behavioral Health Treatment (RB-BHT) |
| | Specialized Consultative Services |
| | Substance Abuse Comprehensive Outpatient Treatment |
| | Substance Abuse Intensive Outpatient Program |
| | Substance Abuse Medically Monitored Community Residential Treatment |
| | Substance Abuse Non-Medical Community Residential |
| | NO CIS SERVICES: COMMUNITY BEHAVIORAL HEALTH ONLY |

The undersigned attests that the provider organization complies with all applicable requirements within NC Clinical Coverage Policies. The undersigned further acknowledges and understands that any material misrepresentation made to NC Medicaid regarding this Attestation may result in an investigation by NC Medicaid and/or impact the organization's eligibility to participate in the NC Medicaid program.

Printed Name of Office Administrator: _____

Signature of Office Administrator: _____

Date: _____